

U.S. Department of Labor

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In the Matter of

CLARENCE LaFOUNTAINÉ,

Claimant,

v.

FOSS MARITIME,
Self-Insured Employer.

January 27, 2000

CASE NO. 1999-LHC-2129

OWCP NO. 14-125524

Appearances:

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For the Employer and Insurer

Before: Paul A. Mapes
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This case involves a claim arising under the Longshore and Harbor Workers' Compensation Act, as amended (hereinafter, the "Act" or the "Longshore Act"), 33 U.S.C. §901 et seq. A trial on the merits of the claim was held in Seattle, Washington, on November 16, 1999. Both parties were represented by counsel and the following exhibits were admitted into evidence: Claimant's Exhibits (CX) 1-17 and Employer's Exhibits (EX) 1-16. Testimony was received from one witness, the claimant. In addition, as authorized during the trial, in January 2000 the employer submitted the

transcript of a post-trial deposition of vocational counselor Merrill Ann Cohen. That transcript has been admitted into evidence as Employer's Exhibit 17.

BACKGROUND

The claimant, Clarence LaFontaine, was born on December 26, 1947, and graduated from high school in 1966. Tr. at 29. Thereafter, he attended Evergreen State College for three years, but did not obtain a degree. CX 9 at 115, CX 16 at 162. In 1968, he received six weeks of vocational training in welding. Tr. at 29, CX 16 at 162. In 1977 he began working as a shipyard welder and in 1990 began working as a boilermaker-leadman for Foss Maritime (hereinafter referred to as "Foss" or "the employer"). Tr. at 30-31, EX 13 at 97.

While employed as a boilermaker-lead man by Foss on June 19, 1997, the claimant slipped and fell after crawling through a lighterage access hole on a tugboat undergoing repairs in a Seattle shipyard. Tr. at 33-34, EX 2 at 6. According to the claimant's trial testimony, as he was attempting to stand upright after emerging from the hole, he lost his footing on a wet deck and grabbed the bottom part of the lighterage hole, thereby jerking his left arm. Tr. at 33-36, 54. Thereafter, the claimant finished his shift and did not report the incident until the next day. Tr. at 36-37, EX 2 at 7. According to an injury report that was apparently filled out by the claimant on June 20, 1997, the only body parts injured during the accident were his left knee and right foot. EX 2 at 6.

On June 23, 1997, the claimant sought treatment from his family physician, Dr. John P. Morris. CX 3 at 72-73. Dr. Morris' report from that date notes that the claimant injured his left knee when he slipped and fell, but does not mention any other injury. Id. Dr. Morris again examined the claimant on June 27, and found "slightly warm" left knee patellar bursa, but normal ligaments and a full range of motion. CX 3 at 71. On July 2, 1997, the claimant was seen for a third time by Dr. Morris. This time, Dr. Morris' report stated that, in addition to injuring his left knee on June 19, the claimant had also apparently "injured his left arm" when he pulled himself through the lighterage hole and worsened a pre-existing right foot condition while climbing a ladder. CX 3 at 70. Dr. Morris noted the claimant had some pain on resisted supination of the left arm that was consistent with a diagnosis of lateral epicondylitis. CX 3 at 70. He also found that the claimant had left lateral epicondyle tenderness but no swelling or loss of range of motion in his left elbow or wrist. Id. Dr. Morris' report also described the left knee injury as probably being a "contusion" and noted there was no history of previous left arm pain. Id.

On the recommendation of Dr. Morris, the claimant visited Dr. David M. Witham on July 27, 1997 for evaluation of his knee injury. CX 7 at 87. At that time, the claimant complained of "persistent pain" in the knee as well as intermittent swelling. Id. Dr. Witham found no "specific indication" for a further workup and recommended "a short course of physical therapy." Id. The claimant returned to Dr. Witham on August 8, 1997, and according to Dr. Witham's report, was so much improved after undergoing physical therapy that he "could return to work on an unrestricted basis." CX 7 at 88. Likewise, after a September 4, 1997 exam, Dr. Witham again concluded that the claimant could "pursue gainful employment with respect to his knee." CX 7 at 89.

During the months of July, August and September, the claimant was seen by Dr. Morris on at least six occasions, but Dr. Morris' notes for that period do not mention any further left arm problems until September 16, 1997. CX 3 at 65-69. At that time, Dr. Morris commented that the claimant had "apparently" injured his left arm during the June 19 accident but added that he could not recall having previously treated the arm. CX 3 at 65. He also noted that the claimant had reported experiencing pain on the lateral side of his left elbow which had been exacerbated by wall pushups recommended for treatment of his foot problem. Id. Dr. Morris further reported that his physical examination of the claimant's left arm found tenderness over the lateral epicondyle and elicited complaints of pain on resisted supination. Dr. Morris added that the complaints of pain on supination were consistent with the diagnosis of lateral epicondylitis. CX 3 at 65.

On September 29, 1997, Dr. Morris again examined the claimant. CX 3 at 64. At that time, he noted that the claimant was still limping and still had tenderness in his right foot and left elbow. Id. Dr. Morris concluded that he did not feel that the claimant "would be able to return to his former job, which included climbing up and down ladders and crawling from one tank in the ship to the next, for some time, at least six months." CX 3 at 64.

Dr. Morris next examined the claimant on December 8, 1997, at which time the claimant complained of continued pain in his left knee, right foot, and left elbow and new pain in his left shoulder. CX 3 at 63. Dr. Morris found tenderness in the medial side of the claimant's knee, but concluded that the ligaments were intact and the range of motion was normal. When he examined the claimant's left arm he found no tenderness in the lateral epicondyle and no pain with resisted supination. He did, however, find the range of motion in the claimant's left shoulder to be limited to about 90 degrees of abduction. Dr. Morris commented that the pain in the claimant's left shoulder might be attributable to "nonuse of his arm" and recommended that the claimant undergo an "IME" to "look at his long term prognosis." CX 3 at 63.

Accordingly, the employer's claims administrator arranged to have the claimant evaluated by Dr. Kevin R. McNamara, an orthopedic surgeon. CX 10 at 122. When Dr. McNamara examined the claimant on January 14, 1998, the claimant complained of continuing discomfort and pain in his right foot, left knee, and left elbow. Dr. McNamara's examination of the claimant left arm revealed no crepitus, swelling or erythema in the elbow, but did elicit reports of tenderness about the claimant's lateral epicondyle. Id. at 128. The examination of the claimant's left knee found some mild constant patellofemoral crepitus and tenderness along the medial patellar facet. Dr. McNamara diagnosed the claimant's complaints as lateral epicondylitis of the left elbow, which he opined was related to industrial exposure on a "more probable than not" basis, and posttraumatic chondromalacia patella of the left knee. Id. at 130. He ordered x-rays of the claimant's elbow and recommended that it be treated with physical therapy and medication. As well, Dr. McNamara also ordered an MRI of the claimant's knee to rule out the possibility of any internal derangement, but added that if there were no significant MRI findings, the claimant's knee could be considered fixed and stable. He also added that if the knee was fixed and stable, it would not warrant any permanent partial impairment rating under the fourth edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. Id. at 131. Five days later, the claimant underwent a left knee MRI, which was interpreted by Dr. Sherrie Chatzkel as showing abnormal signals that were consistent with

“myxoid degeneration” of both the lateral and medial menisci, but no “frank tears.” CX 10 at 133. On the same day, Dr. Chatzkel also interpreted x-rays of the claimant’s left elbow as being normal. Id. at 134.

On February 4, 1998, Dr. Morris again saw the claimant and noted that he “continues to have pain in his right arm and difficulty lifting.” Dr. Morris found tenderness over the lateral epicondyle, but no muscle wasting. He also noted that a neurological examination of “the upper extremity” was normal.¹ CX 3 at 61. On March 2, 1998, Dr. Morris examined the claimant’s left arm and found a full range of motion as well as an absence of tenderness over the left lateral epicondyle. He thus described the results of the exam as being “pretty normal.” CX 3 at 60.

On April 20, 1998, Dr. Morris noted that the claimant was “now starting to develop some pain in his left shoulder and an inability to abduct his left shoulder over 90 degrees.” CX 3 at 58. He also reviewed Dr. McNamara’s report and agreed with his diagnosis of left arm lateral epicondylitis and posttraumatic chondromalacia patella in the left knee. He also agreed that both conditions were related to the claimant’s work injury. Dr. Morris further concluded that the claimant’s left knee condition was “probably fixed” and would not be likely to get any better without weight loss. He did not believe, however, that the claimant’s left arm condition was fixed, and he was therefore unable to set forth any job limitations. Dr. Morris also opined that the claimant’s knee pain would preclude him from the kind of ladder climbing required by his job as a boilermaker. CX 3 at 58. In addition, Dr. Morris also indicated that the claimant was being referred back to Dr. Witham for evaluation of the left elbow and left shoulder conditions. Id.

On April 23, 1998, Dr. Witham examined the claimant and sent Dr. Morris a letter in which he reported that he found the claimant’s neck range of motion to be full and the strength in his left arm to be excellent except when the arm was abducted over 90 degrees, when there was weakness attributable to discomfort. CX 7 at 91. Dr. Witham also noted that there was tenderness over the superoanterior rotator cuff and that a full passive range of motion in the shoulder. He characterized x-rays of the left shoulder as being normal and indicated that it was his “impression” that the claimant’s condition consisted of left shoulder rotator cuff tendinitis, impingement syndrome, subacromial bursitis and left lateralepicondylitis. CX 7 at 91. Dr. Witham recommended physical therapy and various injections for the left shoulder and elbow. Id.

On June 4, 1998, Dr. Witham again wrote to Dr. Morris concerning the treatment of the claimant’s left arm complaints. CX 7 at 93. Dr. Witham noted that the claimant reported feeling stronger after completing a course of physical therapy but continued to complain of pain that was severe enough to prevent him from returning to work. CX 7 at 93. Dr. Witham also indicated that

¹Although Dr. Morris’ report refers to symptoms in both the claimant’s arms, the report does not state which upper extremity was given the neurological examination. However, it appears more likely than not that the statement indicating that the claimant complained of “right” arm pain was mistaken and that Dr. Morris actually meant to refer to left arm pain.

his most recent examination had revealed “a painful arc of motion from 70 to 110 degrees,” but showed no strength reduction with the arm in an adducted position. Dr. Witham indicated that it was his “assessment” that the claimant’s condition consisted of “chronic left shoulder tendinitis and left lateral epicondylitis.” CX 7 at 93. He further concluded that surgery would not be appropriate for these conditions and recommended that they be treated conservatively. Dr. Witham also opined that instead of keeping the claimant off work, efforts should be made to move him toward vocational rehabilitation or a job he feels capable of doing. CX 7 at 93.

About a week later, Dr. Morris examined the claimant and noted that he could not see any changes in claimant’s condition over the last several months. He therefore opined that the claimant’s condition was fixed. CX 3 at 54. He added that, because of the claimant’s ongoing knee and arm problems, it did not look like the claimant would be returning to his “former type of employment.” Id. In his notes of a July 8, 1998 examination, Dr. Morris repeated his conclusion that the claimant’s condition had become fixed and stable. CX 3 at 52.

On July 14 and 15, 1998, the claimant underwent a “performance -based functional capacities evaluation” under the direction of Robert Henderson at HealthSouth Industrial Rehabilitation Clinic in Seattle. CX 8. According to the clinic’s report, the claimant was asked to respond to a series of verbal and written questions concerning his subjective perception of his physical limitations and given a musculoskeletal evaluation by a physical therapist. In addition, the claimant was also given several physical performance tests, including tests designed to measure his hand dexterity, whole body range of motion, lifting ability, and grip strength. The clinic’s report indicated that claimant considered himself able to do very few tasks without discomfort and had varying degrees of pain in his neck, left arm, left knee and right foot. The physical therapist’s evaluation noted that the claimant had “consistent symptoms of lateral epicondylitis” of the left forearm and showed signs of “calcific change” in his left clavicle. CX 8 at 99. The claimant scored no higher than the seventh percentile on a pegboard hand dexterity test and no higher than the 40th percentile on a hand tool dexterity test. The report’s summary listed the claimant’s primary limiting factors as: “inability to squat/kneel to do activities below waist level, and inability to get upper extremity above shoulder height for bilateral activities above shoulder level.” Id. at 94. The summary also concluded that the claimant “could consistently function at the sedentary level on a full-time basis,” but might need to participate in a work conditioning program to build up a better level of fitness necessary for retraining.

Sometime thereafter, the claimant began participating in a work hardening program, but according to notes made by Dr. Morris in September of 1998, progress was very slow and he was discharged from the program without showing “much improvement.” CX 3 at 47, 48. On October 5, 1998, Dr. Morris sent Foss a letter in which he reported that although the claimant had completed the working hardening program, his physical functioning had not changed significantly from the findings set forth in the July 1998 report of the HealthSouth Industrial Rehabilitation Clinic. CX 3 at 46. Dr. Morris further noted that at that time, the claimant was only capable of performing sedentary work. Id.

In November of 1998, the claimant was referred by Dr. Morris to United Backcare where he was evaluated by a physician, physical therapist, vocational specialist and psychologist. CX 9. The

physician who examined the claimant, Dr. Tom Feher, characterized the claimant's account of his medical history as being "circuitous and frequently vague." Dr. Feher further indicated that when he examined the claimant's neck, the neck was resistant to passive movement and its movement caused the claimant to complain of pain which was localized on the left. CX 9 at 108. Dr. Feher also noted that the claimant would not flex or abduct his left arm more than 30 to 40 degrees at the shoulder and observed that there was crepitus in both his knees but no evidence of instability. Dr. Feher's diagnosis was lateral epicondylitis of the left elbow, post-traumatic condromalacia of the left knee and recurrent plantar fasciitis, all "by history." CX 9 at 109. The psychologist who examined the claimant, Dr. Michael D. Harris, reported that the claimant's answers to questions on an MMPI-2 exam were "consistent with both pain patient characteristics and mild depression." CX 9 at 120. Dr. Harris also noted that the validity scale on the MMPI-2 indicated that the claimant was "generally candid in the way he presented himself on the test." Dr. Harris further reported that the results of a Waddell Fear-Avoidance Behavior Questionnaire indicated that fear of increased symptoms and re-injury were playing a substantial role in the claimant's current disability behaviors. CX 9 at 120. In a cover letter summarizing the results of the evaluation, Dr. Feher recommended that the claimant be admitted to United Backcare's "Return to Work-Pain Management Program." CX 9 at 106.

On December 29, 1998, the claimant was again examined by Dr. Morris, who reported that at that time the claimant's "most troublesome symptom" was left elbow and shoulder pain. CX 3 at 39. Dr. Morris commented that he believed the shoulder pain was secondary to the pain and lack of range of motion in the elbow and added that the claimant's symptoms had worsened since he stopped going to physical therapy. Id. Dr. Morris also reported that the claimant "is now definitely losing muscle mass" in his left arm and indicated that the circumference of the claimant's left forearm was two centimeters smaller than the circumference of his right arm. Id. In treatment notes dated January 25, 1999, Dr. Morris reported that the claimant had returned to physical therapy and commented that an unnamed physical therapist had also noted "wasting" in the claimant's left forearm. CX 3 at 37. In treatment notes dated February 22, 1999, Dr. Morris indicated that the results of his examination of the claimant's left knee were "normal" but that there was still a one centimeter difference in the circumferences of the claimant's forearms. CX 3 at 36.

At some unspecified date in the Spring of 1999, Dr. Morris referred the claimant to Dr. Deborah Amos, a physiatrist. CX 2 at 33. The claimant was first examined by Dr. Amos on May 4, 1999. CX 17 at 5. He complained of dull aching pain in his neck and left trapezius as well as sharp, electric pains in his left forearm that were worse when reaching or with neck movement. CX 2 at 29-30. The claimant also asserted that he was generally tired and had trouble concentrating. Dr. Amos' physical examination indicated that there was muscle "atrophy" in the left shoulder deltoid muscle, a positive Hoffman's test on the left, and active left shoulder abduction that was limited to approximately 90 degrees. CX 2 at 29-31. Among other things, Dr. Amos recommended that the claimant have an EMG performed to detect any cervical radiculopathy, neck x-rays, and a cervical MRI. CX 2 at 32.

As suggested by Dr. Amos, on May 7, 1999, Dr. Raymond W. Valpey performed electrodiagnostic studies of the claimant's left arm. EX 10. According to Dr. Valpey's report, the

results of these tests were all “normal ” and and showed no electrodiagnostic evidence of motor radiculopathy, radial neuropathy, or median neuropathy. Id.

On May 10, 1999, Dr. Morris sent Foss a letter in which he reported that the claimant’s condition was worsening and requested that job searches and job training be held in abeyance. CX 3 at 34. He also informed Foss that Dr. Amos would be taking over responsibility for providing care to the claimant.

On June 1, 1999, Dr. Amos again examined the claimant and found that abduction and external rotation were decreased when his left shoulder was examined for passive range of motion. CX 2 at 27. Dr. Amos also noted that crepitus was “palpable” in the claimant’s left shoulder and that sensation was “subjectively decreased” throughout much of the claimant’s left arm. CX 2 at 27-28. On this same day, Merrill A. Cohen, a vocational rehabilitation counselor retained by Foss, submitted a report in which she concluded that on the basis of the physical restrictions described in the July 1998 “Performance Based Functional Capacities Evaluation,” the claimant was incapable of returning to work as a boilermaker-leadman. EX 13. However, Ms. Cohen also concluded that the claimant was capable of performing alternative types of work and specifically identified eight such jobs that she had found to be available to job seekers in the Seattle area during the period between April 2 and 28, 1999. Id. Among these alternative jobs were dispatcher, customer service representative, telemarketer, appointment setter, bench assembler, and parking cashier positions. Id. The wages for these jobs ranged from \$6.00 to \$11.00 per hour. Id. Attachments to the report indicate that Ms. Cohen had sent the claimant information about these job openings as soon as she became aware of them. Id.

On June 7, 1999, Foss determined that the claimant had the ability to perform one of the jobs identified in Ms. Cohen’s labor market survey and therefore reduced his weekly compensation payments from \$468.90 to \$202.23. CX 1 at 5-7.

On June 30, 1999, Foss had the claimant evaluated by Dr. Richard G. McCollum, a board-certified orthopedic surgeon. CX 11 at 136, EX 12. In his report to the employer’s counsel, Dr. McCollum summarized many of the claimant’s treatment records and set forth the results of his own physical examination of the claimant. In describing the results of the physical examination, Dr. McCollum noted that the claimant reported decreased sensation to pinpricks in various areas of his left hand and arm, but added that any sensory deficit “was in a nondermatomal pattern.” Id. He also found shoulder flexion and abduction to be greater on the right than on the left, but indicated that he observed no atrophy, tenderness, swelling, redness, or crepitus in the left shoulder. Id. The report further indicated that the circumference of the claimant’s right forearm was two centimeters greater than the circumference of his left forearm and that the claimant’s right upper arm circumference was one centimeter larger than his left upper arm circumference. CX 11 at 141. In concluding the report, Dr. McCollum commented that the claimant did not provide maximum cooperation in the range of motion testing and noted that the claimant did not move his right shoulder “very well,” even though there is no alleged problem with that shoulder. Dr. McCollum also concluded that there were “no positive objective findings” that would justify any further diagnostic or therapeutic measures and asserted that he didn’t “see any evidence” that the claimant had either a cervical or shoulder condition

related to his June 1997 injury. CX 11 at 142. He also opined that he did not see any reason why the claimant could not return to the same type of work he was performing at the time of that injury. CX 11 at 142. Finally, Dr. McCollum opined that the combination of the claimant's symptoms and "bizarre physical findings" does not support a clinical diagnosis of on-going musculoskeletal problems. CX 11 at 143.

On July 1, 1999, Dr. Amos completed a Department of Labor work capacity evaluation form in which she indicated that in her opinion the claimant was at that time precluded from performing overhead work, repetitive hand movements, prolonged wrist flexion and extension, lifting more than 20 pounds, prolonged grasping and tasks requiring more than occasional kneeling, standing or bending. CX 16 at 170-71. She further opined that any return to work should begin gradually and should not be full time until after the claimant had worked part-time for at least a month.

On July 7, 1999, a vocational rehabilitation report was prepared by Michael Richards, a certified vocational counselor who had been retained by the Department of Labor to provide vocational rehabilitation services to the claimant. CX 16 at 160-73. Mr Richards noted that his attempts to perform this assignment were being impeded by a series of obstacles, including the instability of the claimant's medical condition, as well as the claimant's lack of vocational goals and focus on his conflicts with Foss. Mr. Richards concluded that the claimant was unlikely to make much progress toward finding new employment until his medical and legal issues were resolved. CX 16 at 168.

On July 12, 1999, Ms. Cohen submitted a supplemental report in which she indicated that she had recently identified eight more job openings in the Seattle area that would be suitable for a person with the physical capabilities described in the HealthSouth Industrial Clinic's July 1998 "Performance Based Physical Capacities Evaluation." EX 13 at 124-49. A copy of the job survey results was also simultaneously sent to the claimant. EX 13 at 126. The eight job openings identified by Ms. Cohen included three openings for dispatchers, two openings for security guards, and single openings for a driver, bench assembler, and appointment setter. Id.

On July 12, 1999, the claimant was seen by Dr. Michael E. Blatner, a hand surgeon, for evaluation of the complaints of pain in his forearm. CX 17 at 11. In his report to Dr. Amos, Dr. Blatner's opined that the claimant's left arm was "remarkable for a decrease in the muscle mass of the forearm" which appeared to Dr. Blatner to be "more of a generalized wasting" than a loss in any specific muscle or muscle group. CX 5 at 78. Dr. Blatner's report further noted that the claimant's left shoulder "appears smaller in muscle mass" than the right shoulder, but commented the difference might be due to the claimant's posture. Id. The report also indicated that the claimant described palpation of his lateral epicondyle as being "extremely painful" and complained of pain in the left side of his neck. CX 5 at 78-79. Dr. Blatner's "impression" of the claimant's condition was left lateral epicondylitis, altered radial sensory nerve distribution of the left arm and forearm, and left hand, forearm, arm, and neck pain of uncertain etiology. In concluding his report, Dr. Blatner speculated that the claimant's symptoms might be attributable to an injury "at the level of the brachial plexus" and commented that there may have been "a stretch-traction injury that occurred during the June 1997 accident." CX 5 at 79.

On July 15, 1999, Dr. Amos again examined the claimant. She noted that the claimant was still reporting left knee and left arm pain and commented that he appeared to be experiencing some impingement in his left shoulder. She also observed that the claimant had symptoms of possible depression and therefore decided to refer him to a psychologist for evaluation. Dr. Amos further noted that the claimant's condition was not fixed and stable and that she had not yet released him to return to work. At the report's conclusion, she indicated that she was continuing to "strongly" recommend that the claimant be given an MRI of his neck and left shoulder. CX 2 at 20-22.

On July 19, 1999, the claimant was evaluated by physical therapist Michael Egbert at the request of Dr. Amos. Mr. Egbert concluded that it was clear the claimant was in need of a physical therapy "on a comprehensive level from nearly head to toe." CX 12 at 146.

On July 26, 1999, the claimant was again seen by Dr. Blatner. In his report from that date, Dr. Blatner agreed with Dr. Amos that the claimant's left arm symptoms might possibly be attributable to a brachial plexus injury and that such an injury might have been caused by a traumatic stretching or by a "direct injury." CX 5 at 80. Dr. Blatner also indicated that there was nothing in the claimant's left hand or forearm that he could treat further. He therefore recommended that any additional treatment be provided by Dr. Amos. Id.

On July 26, 1999, the claimant's left knee was examined Dr. Scott E. Hormel. CX 6 at 82. In his report to Dr. Amos, Dr. Hormel indicated that the examination revealed some tenderness along the medial joint line and in the medial parapatellar region, but no other abnormalities. Dr. Hormel further commented that on an "overall" basis, the claimant seemed to have symptoms which "were out of proportion" to his findings during the physical examination. On August 3, 1999, Dr. Hormel reviewed the films of the 1998 MRI of the claimant's left knee and agreed with the radiologist's conclusion that the MRI showed "muroid degeneration of the medial meniscus" but did not indicate the presence of an "obvious tear." However, because of the claimant's continuing pain complaints, he recommended that the claimant be given an MRI with gadolinium for the purposes of ruling out a meniscus tear. He added that if no such tear was shown, "this claim needs to be closed." CX 6 at 83. Thereafter, a second left knee MRI was performed which showed a "degenerative horizontal cleavage tear" in the lateral meniscus that was characterized as being "small in size." CX 6 at 84-85. After reviewing these results, Dr. Hormel noted that the medial meniscus, which had been the site of the claimant's post-injury symptoms, "was completely normal." He therefore concluded that surgery on the knee would not be of much benefit. CX 6 at 86.

On July 28, 1999, Dr. Amos again examined the claimant. She noted in her records that there was "muscle atrophy" around the claimant's left shoulder girdle and throughout much of his left arm and forearm. In addition, she observed that the active range of motion in the claimant's left shoulder was impinged, but his passive range of motion was unremarkable. CX 2 at 19-20.

On August 20, 1999, an MRI of the claimant's cervical spine was performed by Dr. Shane Macaulay. CX 2 at 17-18. According to Dr. Macaulay's report, it showed a straightening of the normal cervical lordosis, some multilevel loss of vertebral body height that was "most likely

developmental or degenerative,”some small disc protrusions at C4-5 and C6-7, and a small to moderate protrusion at C5-6 which indented the spinal cord.

On August 26, 1999, the claimant visited Dr. Amos and told her that his physical therapy sessions had been a “torture chamber” which had caused his pain to “skyrocket.” CX 2 at 13. Dr. Amos noted that the MRI of the claimant’s cervical spine showed disc protrusions, but commented that in her opinion the protrusions were “quite small.” She also performed a physical examination and noted that there still appeared to be “some atrophy” around the claimant’s left shoulder. In addition, she performed various EMG studies which she found showed “[n]o electrodiagnostic evidence of left radiculopathy, ulnar neuropathy, median neuropathy, carpal tunnel syndrome, or thoracic outlet syndrome.” Id. at 16.

On August 31, 1999, Dr. Phillip Knowles, a psychologist, reported to Dr. Amos that he had met with the claimant on three occasions and given him various psychological tests. CX 17 at 13. Among other things, Dr. Knowles, indicated that on a psychological test called the Symptom Checklist 90 (SCL-90) the claimant “scored essentially off of the scale on somatization, obsessive-compulsiveness and depression.” CX 4 at 75. Likewise, Dr. Knowles reported that the claimant’s answers to questions asked on the Millon Clinical Multiaxial Inventory-II (MCMI-II) indicated that the claimant was “experiencing a moderately severe mental disorder” with a “strong somatic component.” It was further noted that although these results appeared to conflict with the claimant’s minimal “depression and anxiety scores” and average “somatization scores” on the Pain Patient Profile (P-3), the conflict could be due to the fact that these tests “are normed on quite different populations.” CX 4 at 75. Dr. Knowles concluded that the claimant “could benefit from regular psychotherapy visits.” CX 4 at 76.

On September 23, 1999, Dr. Amos performed another physical examination and noted continued muscle atrophy around in the claimant’s left shoulder. CX 2 at 11. In addition, she also observed “clicking” in the claimant’s left shoulder and left-sided “scapular winging” that was not apparent on the right side. She recommended that the claimant resume physical therapy and begin receiving psychotherapy from Dr. Knowles, but noted that the “insurance company” was refusing to pay for either type of treatment. CX 2 at 11-12. On this same day, Dr. Amos sent the claimant’s attorney a letter in which she disputed the conclusions set forth in Dr. McCollum’s report of June 30, 1999. CX 2 at 9, 10. Among other things, she asserted that Dr. McCollum’s description of the claimant’s injury failed to acknowledge that the claimant had apparently grabbed at an opening with his left arm and contended that this type of occurrence “could have caused a traction-type injury to the left arm and shoulder, possibly a brachioplexopathy.” CX 2 at 9. Dr. Amos also disagreed with Dr. McCollum’s conclusion that there was no muscle atrophy in the claimant’s left shoulder and asserted that, contrary to Dr. McCollum’s finding, she had “consistently seen muscle atrophy, as well as winging of the left shoulder.” Id. She also disagreed with Dr. McCollum’s opinion that the claimant was ready to return to work.

On September 29, 1999, the claimant was seen at the request of Dr. Amos by Dr. Kim B. Wright, a neurosurgeon. CX 15 at 159a. Dr. Amos referred the claimant to Dr. Wright because she thought the claimant’s pain and atrophy could be caused by the nerves in his neck. CX 17 at 13-14.

Dr. Wright's examination found that the claimant had a limited range of motion in his neck attributable to pain complaints; that both his neck and left shoulder were tender to palpitation; that he demonstrated marked guarding and limitation of motion in the left shoulder, especially in abduction; and that he was tender over the lateral epicondyle of the left elbow. Dr. Wright reported that these physical findings might be symptomatic of some type of frozen shoulder problem or impingement within the shoulder. CX 15 at 159b. Dr. Wright concluded that the claimant was not yet a candidate for neurosurgery, but should be seen by two other physicians: Dr. Pierce Scranton, an orthopedic surgeon, and Peter Mohai, a rheumatologist. Id. at 159b, CX17 at 14.

On October 14, 1999, Mr. Richards prepared a second report in the claimant's vocational progress. He noted that the same issues still confronted the claimant and were frustrating his vocational rehabilitation. CX 16 at 177. He also commented that Foss had repeatedly failed to respond to his attempts to get the company to cooperate in his efforts to vocationally rehabilitate the claimant. CX 16 at 178.

ANALYSIS

The parties agree: (1) that the claimant suffered an injury to his left knee, right foot, and left elbow during an accident occurring on June 19, 1997, (2) that the accident happened at a maritime situs and while the claimant was working in a maritime status, (3) that the accident arose out of and in the course of the claimant's employment by Foss, (4) that both the claim for benefits and notice of the alleged injuries were timely, and (5) that there is no dispute concerning entitlement to any additional benefits for the injury to the claimant's right foot. All of these stipulations, including the stipulation concerning situs and status, have been found to be fully supported by the evidence and are hereby adopted as findings of fact. The following issues are in dispute: (1) whether the claimant did in fact suffer left shoulder injuries arising out of and in the course of his employment, (2) whether any of the claimant's injuries have reached the point of maximum medical improvement, (3) the extent of any disabilities resulting from the claimant's injuries, (4) the calculation of the claimant's average weekly wage, and (5) the claimant's entitlement to medical care recommended by Dr. Amos.

1. Compensability of the Alleged Left Shoulder Injuries

Under subsection 2(2) of the Act, a worker's injury is not compensable unless the injury arose out of and in the course of the worker's employment. In proving that an injury arose out of and in the course of employment, a claimant is aided by subsection 20(a) of the Act, which provides that in proceedings to enforce a claim under the Act, "it shall be presumed, in the absence of substantial evidence to the contrary ... (a) that the claim comes within the provisions of the Act...." However, in order to invoke this presumption, a claimant must prove that he or she suffered some harm or pain and that working conditions existed or an accident occurred that could have caused the harm or pain. See, e.g., Kalaita v. Triple A Machine Shop, 13 BRBS 326 (1981). Thus, a claimant has the burden of proving the existence of working conditions or an accident that could have caused his or her impairment, and merely proving that some sort of impairment exists is not enough to warrant invocation of the presumption. U.S. Industries/Federal Sheet Metal, Inc. v. Director, OWCP, 455 U.S. 608, 102 S. Ct. 1312, 1317 (1982) ("The mere existence of a physical impairment is plainly

insufficient to shift the burden of proof to the employer."). However, a claimant is entitled to invoke the presumption if he or she adduces at least "some evidence tending to establish" both prerequisites and is not required to prove such prerequisites by a preponderance of the evidence. Brown v. I.T.T./Continental Baking Co., 921 F.2d 289, 296 n.6 (D.C. Cir. 1990)(emphasis in original). Once the subsection 20(a) presumption has been properly invoked, the employer is assigned the burden of presenting substantial evidence to counter the presumed relationship between the claimant's impairment and its alleged cause. Dower v. General Dynamics Corp., 14 BRBS 324 (1981). If the presumption is rebutted, it falls out of the case and the administrative law judge must weigh all of the evidence and resolve the issue based on the record as a whole. Hislop v. Marine Terminals Corp., 14 BRBS 927 (1982). Under the decision of the Supreme Court in Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994), the ultimate burden of proof then rests on the claimant.

In this case, the claimant contends that he has presented evidence sufficient to satisfy both requirements for invocation of a subsection 20(a) presumption that he has a work-related shoulder impairment. Among other things, he asserts, the first requirement has been satisfied by the medical examinations showing the presence of shoulder abnormalities such as atrophy and by his own complaints of shoulder pain and other symptoms. The second requirement, he contends, has been met by statements from Dr. Amos and Dr. Morris indicating that in their opinion the shoulder abnormalities were or could have been caused by the claimant's June 19, 1997 work injury. In response, the employer contends that neither of two requirements for invoking the subsection 20(a) presumption has been satisfied. In particular, the employer contends, the first requirement has not been met because there are no actual shoulder abnormalities and the claimant's descriptions of his alleged shoulder symptoms are not credible. Further, the employer asserts, Dr. Amos' opinion concerning the cause of the claimant's shoulder condition is based on an inaccurate version of the work injury and Dr. Morris' opinions on this issue have been confusing and contradictory.

Although, the employer has offered some clear reasons for questioning the evidence purportedly showing the existence of a shoulder impairment and for doubting the validity of the opinions of the claimant's physicians concerning the cause of that alleged impairment, I find that on balance the evidence submitted by the claimant on these two questions is more than sufficient to satisfy the "some evidence" standard set forth in Brown v. I.T.T./Continental Baking Co. Accordingly, unless the employer has produced substantial evidence to the contrary, it must be presumed that the claimant has a work-related shoulder impairment.

In contending that the subsection 20(a) presumption has been rebutted, the employer relies entirely on Dr. McCollum's pre-trial deposition testimony and June 30, 1999 report. According to this testimony and report, it is Dr. McCollum's professional opinion that there is no medically reliable evidence of any cervical or shoulder impairment related to the claimant's June 19, 1997 work injury. EX 15 (deposition testimony), CX 11 at 142 (report). I find that this evidence is by itself substantial enough to rebut the subsection 20(a) presumption. Accordingly, it is necessary to weigh all of the evidence in order to determine if the claimant has shown a causal relationship between his employment and his alleged shoulder impairments by a preponderance of the evidence.

After weighing all of the relevant evidence, I find that the claimant has provided just barely enough evidence to warrant a finding that he has a worked-related left shoulder impairment. There are three reasons for this conclusion.

First, although Dr. McCollum has asserted that he found no objective evidence of any left shoulder impairment and testified that there is no medical basis for the claimant's complaints of constant left arm pain, several other well-qualified physicians have found at least some objective evidence of a left shoulder and arm impairment. Most significantly, Dr. Amos, Dr. Morris and Dr. Blatner have all observed what they described as atrophy in the claimant's left arm. Although Dr. McCollum has suggested that such observations might be attributable to the fact that the claimant is right-handed, it seems highly unlikely that any of the physicians who reported left-arm "atrophy" would have used such a pathological term to describe a normal variation between dominant and non-dominant arms. Moreover, Dr. Amos has also reported left shoulder crepitus, limitations of left shoulder motion, and left-side "scapular winging."

Second, although the medical and accident reports prepared immediately after the claimant's work injury do not contain any reference to any left arm injuries, the records prepared by Dr. Morris do show that about two weeks after the June 19, 1997 accident the claimant did complain that he had also "injured his left arm" during the accident. CX 3 at 70. Moreover, there is absolutely no evidence in the record suggesting that there is any other possible explanation for the claimant's left arm symptoms.

Third, although the medical reports in this case contain differing descriptions of the mechanics of the claimant's work injury, these variations are not so substantial that they constitute convincing evidence that the claimant has been attempting to mislead physicians about how the injury occurred. In this regard, it is noted that these medical reports contain only brief summarizations of what the authors understood the claimant to be saying when he described his accident and do not purport to set forth verbatim accounts of the claimant's statements concerning the mechanics of his injury. Moreover, long experience in reviewing medical reports has shown that apparent conflicts in physicians' descriptions of the mechanics of a longshore worker's injury are quite often attributable to the physicians' erroneous assumptions and misinterpretations of maritime terminology.

2. Date of Maximum Medical Improvement

A disability is considered permanent on the date a claimant's condition reaches maximum medical improvement or if the condition has continued for a lengthy period of time and appears to be of lasting or indefinite duration. Watson v. Gulf Stevedore Corp., 400 F.2d 649 (5th Cir. 1968), cert. denied, 394 U.S. 976 (1969); Air America, Inc. v. Director, OWCP, 597 F.2d 773, 781-82 (1st Cir. 1979); Crum v. General Adjustment Bureau, 738 F.2d 474, 480 (D.C. Cir. 1984); Phillips v. Marine Concrete Structures, Inc., 21 BRBS 233 (1988). The issue of whether a claimant's condition has reached the point of maximum medical improvement is primarily a question of fact and must be resolved on the basis of medical rather than economic evidence. Williams v. General Dynamics Corp., 10 BRBS 915 (1979); Ballesteros v. Willamette Western Corp., 20 BRBS 184 (1988); Dixon v. John J. McMullen and Associates, Inc., 19 BRBS 243 (1986); Trask v. Lockheed Shipbuilding

and Construction Co., 17 BRBS 56 (1985). The mere possibility that a claimant's condition may improve in the future does not by itself support a finding that a claimant has not yet reached the point of maximum medical improvement. Brown v. Bethlehem Steel Corp., 19 BRBS 200 (1987). However, a condition is not permanent as long as a worker is undergoing treatment that is reasonably calculated to improve the worker's condition, even if the treatment may ultimately be unsuccessful. Abbott v. Louisiana Insurance Guaranty Ass'n, 27 BRBS 192, 200 (1993), aff'd sub. nom Louisiana Insurance Guaranty Ass'n v. Abbott, 40 F.3d 122, 126 (5th Cir. 1994).

In considering medical evidence concerning a worker's injury, a treating physician's opinion is entitled to "special weight." Amos v. Director, OWCP, 153 F.3d 1051 (9th Cir. 1998). In fact, in the Ninth Circuit clear and convincing reasons must be given for rejecting an *uncontroverted* opinion of a treating physician. Magallanes v. Bowen, 881 F.2d 747, 751 (9th Cir. 1989). However, the Ninth Circuit has also held that a treating physician's opinion is not necessarily conclusive and may in some circumstances be disregarded, even if uncontradicted. For example, an administrative law judge may reject a treating physician's opinion that is "brief and conclusionary in form with little in the way of clinical findings to support [its] conclusion." Id. In addition, an administrative law judge can reject the opinion of a treating physician which conflicts with the opinion of an examining physician, if the ALJ's decision sets forth "specific, legitimate reasons for doing so that are based on substantial evidence in the record." Id.

In this case, the employer has taken no position on whether the claimant's shoulder condition has reached the point of maximum medical improvement, but does contend that there has been maximum medical improvement in the claimant's left knee and left elbow conditions. In particular, the employer contends that the left knee condition reached the point of maximum medical improvement on August 8, 1997 and that the left elbow condition became permanent and stationary on either June 10 or October 5, 1998. In contrast, the claimant contends that all of his impairments must be considered together and, when so considered, have not yet reached the point of maximum medical improvement.

I find that because this case involves both an unscheduled injury to the claimant's shoulder and two scheduled injuries (the elbow and knee impairments), maximum medical improvement determinations must be made for each separate impairment. For the reasons set forth below, I further find that the claimant's shoulder and left elbow injuries have not yet reached the point of maximum medical improvement, but that the knee injury became permanent and stationary on January 12, 1998.

A. Shoulder Injury

As indicated in the summary of the medical evidence, there has not yet been a clear diagnosis of the claimant's left shoulder impairment and Dr. Amos is still attempting to diagnose and treat the condition. Accordingly, I find that the shoulder injury has not yet reached the point of maximum medical improvement.

B. Left Elbow

Review of the medical evidence indicates that the claimant's left elbow injury has been diagnosed by Dr. Morris, Dr. McNamara, Dr. Witham, Dr. Amos, and Dr. Blatner as lateral epicondylitis, a condition popularly known as tennis elbow and defined as the inflammation of the epicondyle of the humerus and surrounding tissues. The only physician to have expressed an opinion on whether this specific condition has reached the point of maximum medical improvement is Dr. Morris, who indicated in his notes of June 10, 1998 that he had determined that the condition was "fixed." CX 3 at 54. However, this conclusion was arguably contradicted by Dr. Amos, who testified on November 10, 1999 that on an overall basis the claimant's condition had not yet reached the point of maximum medical improvement. CX 17 at 17. Although Dr. Amos did not specifically include the elbow injury within the scope of this general statement, it is clear from a review of the rest of her testimony and reports that she is still attempting to find more effective treatments for the elbow condition and is at this time apparently unable to distinguish any on-going elbow-injury impairments from the claimant's shoulder injury impairments. Accordingly, I conclude that there is insufficient evidence to warrant a finding that the claimant's left elbow impairment has yet reached the point of maximum medical improvement.

C. Left Knee Injury

As previously explained, the record contains a number of medical reports and opinions concerning the claimant's left knee injury. As these reports indicate, Dr. Morris initially diagnosed the claimant's left knee injury as a probable contusion and about two months later Dr. Witham reported that there had been an "excellent recovery" as a result of physical therapy. However, due to the claimant's later complaints of on-going left knee pain and swelling, he was subsequently referred to Dr. McNamara, who on January 14, 1998 diagnosed the claimant's knee injury as post-traumatic chondromalacia patella and concluded that if there were no significant findings on an upcoming MRI scan, the injury should be considered fixed and stable. Dr. McNamara further concluded that if the knee was fixed and stable, the injury would not warrant any permanent partial disability rating under the AMA Guides. The MRI that was subsequently performed at Dr. McNamara's request showed evidence of "myxoid degeneration" in the lateral and medial menisci, but no "frank tears." Apparently as a result of the MRI's failure to reveal any traumatic injuries, no supplemental report was issued by Dr. McNamara, and in April of 1998 Dr. Morris agreed with his diagnosis of chondromalacia patella. CX 3 at 58. At the same time, Dr. Morris also described the knee condition as being "probably fixed." Thereafter, the evidence shows, the claimant's continued complaints of left knee symptoms caused a referral to Dr. Hormel, who in 1999 requested a second left-knee MRI. That MRI showed what Dr. Hormel characterized as a "very small horizontal tear" in the lateral meniscus. However, Dr. Hormel also noted that the medial meniscus "was completely normal" and opined that a surgical repair to the small lateral tear would not be beneficial because all of the symptoms reported to him by the claimant were on the medial side of his knee. CX 6 at 86. Dr. Amos testified that she does not agree with the diagnosis of post-traumatic chondromalacia and indicated that in her opinion the claimant's left knee injury was merely a "strain." CX 17 at 16, 30. In addition, as already noted, during a pre-trial deposition Dr. Amos opined that the claimant's overall condition had not reached the point of maximum medical improvement but did not specifically

indicate which of the claimant's various injuries had not yet become permanent and stationary. According to Dr. McCollum, the results of his examination of the claimant's left knee were essentially "normal" and the claimant has no permanent disability or restrictions. EX 15 at 16, 18. Dr. McCollum also testified that about third of all adult Americans have degenerative meniscus tears such as those shown on the 1999 MRI but they are not trauma related and most don't need treatment. EX 15 at 19-20.

As the foregoing evidentiary summary indicates, even the claimant's own treating physicians are not in agreement concerning the diagnosis of the left knee injury. Of the various medical opinions, I find the most convincing to be the opinion of Dr. McNamara, who on January 14, 1998 diagnosed the injury as post-traumatic chondromalacia and determined that it had become fixed and stable. This decision to credit the opinion of Dr. McNamara and thereby find that the knee injury reached the point of maximum medical improvement on January 14, 1998 is primarily based on Dr. McNamara's specialized expertise in orthopedic injuries and on the fact that Dr. Morris concurred in his diagnosis. It is of course recognized that Dr. Amos did opine that the claimant's overall condition has not yet reached the point of maximum medical improvement. However, as already mentioned, she did not specifically address the knee injury or explicitly rule out the possibility that the knee had become permanent and stationary. It is further noted that although the 1999 MRI did show the presence of a very small lateral meniscus tear, both Dr. Hormel and Dr. McCollum have provided persuasive reasons for concluding that this tear is unrelated to the claimant's work injury.

3. Extent of Disability

Any claimant who contends that he is disabled has the burden of proving a prima facie case of disability by showing that he cannot return to his regular employment due to his work-related injury. Bumble Bee Seafoods v. Director, OWCP, 629 F.2d 1327 (9th Cir. 1980); Trask v. Lockheed Shipbuilding Co., 17 BRBS 56, 59 (1980). If the claimant meets this burden, the employer must then establish the existence of specific and realistically available job opportunities within the geographic area where the employee resides which a person with the employee's technical and verbal skills is capable of performing. See, e.g., Bumble Bee Seafoods v. Director, Office of Workers' Compensation Programs, 629 F.2d 1327 (9th Cir. 1980); Hairston v. Todd Shipyards Corp., 849 F.2d 1194 (9th Cir. 1988). To satisfy this burden the employer must identify specific jobs that the claimant can perform and obtain. Bumble Bee, supra, at 1330. In considering whether a claimant has the ability to perform particular work, a fact finder must consider the claimant's physical restrictions, technical abilities and verbal skills. In addition, a fact finder must also consider the likelihood that a person of the claimant's age, education, and background would be hired if he or she diligently sought the alternative job identified by the employer. Hairston, supra, at 1196; Stevens v. Director, OWCP, 909 F.2d 1256 at 1258 (9th Cir. 1990). If an employer makes the requisite showing of suitable alternative employment, a claimant may rebut the employer's showing by demonstrating that a diligent effort to obtain such work was unsuccessful. Edwards v. Director, OWCP, 999 F.2d 1374, 1376 n.2 (9th Cir. 1993); Palombo v. Director, OWCP, 937 F.2d 70 (2nd Cir. 1991).

In this case, the claimant contends that he has been totally temporarily disabled since his June 1997 injury. In contrast, the employer contends that the claimant has been able to return to his

former job as a boilermaker-leadman since the date of Dr. McCollum's June 30, 1999 examination. Alternatively, the employer contends that since at least April of 1999 the claimant has been capable of obtaining and performing alternative jobs paying as much as \$11.00 per hour.

For the reasons set forth below, I find that because of the claimant's shoulder impairment he has been temporarily unable to perform his former job as a boilermaker-leadman continuously since June of 1997 and has not been able to obtain suitable alternative employment. I further conclude that the claimant has failed to show that he has any permanent left knee impairment. I thus find that although the claimant is entitled to temporary total disability benefits, he is not entitled to receive any scheduled permanent partial disability benefits for his left knee injury.

A. Claimant's Ability to Return to Work as a Boilermaker-Leadman

In contending that he is at least temporarily incapable of returning to work as a boilermaker-leadman, the claimant apparently relies on the opinions of Dr. Amos and Dr. Morris, both of whom are treating physicians who have opined that the claimant is not capable of returning to that type of work. In contrast, the employer relies solely on the opinion of Dr. McCullum, a non-treating physician who asserts that the claimant has no impairments that would preclude from performing any type of work. As previously indicated, Dr. McCollum's opinion is undermined by his failure to recognize atrophy and other objective evidence of an on-going left arm impairment. For this reason, I find that Dr. McCollum's opinion is less convincing than the opinions of the claimant's treating physicians and conclude that the claimant has met his burden of showing that he is unable to perform the type of work that he was doing at the time of his injury.

B. Availability of Suitable Alternative Employment

In an attempt to satisfy its burden of showing the availability of suitable alternative employment, the employer has submitted the deposition testimony and reports of Merrill Cohen, a certified vocational rehabilitation counselor. EX 13 (reports), EX 17 (deposition testimony). According to Ms Cohen's testimony and reports, she interviewed the claimant on March 23, 1999 and during the following month prepared a labor market survey in which she identified eight available jobs that could be performed by a person with the claimant's vocational characteristics and the physical limitations set forth in the July 1998 report of the HealthSouth Industrial Rehabilitation Clinic. EX 13, EX 17 at 5-8. In addition, in July of 1999, Ms. Cohen produced a second labor market survey in which she reported that she had also identified an additional eight job openings.

The claimant contends that, for a variety of reasons, the employer has failed to meet its burden of showing that the jobs identified by Ms. Cohen do, in fact, constitute suitable alternative employment. For example, the claimant asserts that because his shoulder condition has not yet reached the point of maximum medical improvement, it is therefore too early for him to begin seeking alternative employment. Likewise, he contends that he did make an effort to obtain some of the jobs identified by Foss but was unsuccessful. In addition, the claimant asserts that Ms. Cohen's job survey failed to consider the effect on his employability of his on-going use of narcotic pain

medication. The claimant also contends that the security guard and driver jobs Ms. Cohen identified are precluded by the fact that he has past convictions for driving under the influence of alcohol.

The claimant's contention that suitable alternative employment is *per se* unavailable until he reaches the point of maximum medical improvement is not legally valid. Likewise, his assertion that he made a good faith effort to find alternative employment is not supported by enough credible evidence to meet his burden of proof under Edwards v. Director, OWCP, *supra*. However, after reviewing all of the relevant evidence, I do find that the employer's job market survey is insufficient to show the availability of suitable alternative employment at this time and that the claimant has therefore been totally temporarily disabled since June 20, 1997. There are several reasons for this conclusion.

First, even though Dr. Morris reported in May of 1999 that the claimant's condition had worsened, Ms. Cohen's job market survey is based on a physical capacities evaluation performed almost a year earlier.

Second, although Dr. Amos did provide Mr. Richards with a Work Capacity Evaluation on July 1, 1999 which indicated that the claimant might be able to perform some type of employment if allowed to begin such work on a part-time basis, there is nothing in Ms. Cohen's reports or testimony which indicates that such part-time work was available. Indeed, she testified that all the jobs she identified were full time jobs. CX 16 at 170-71 (Work Capacity Evaluation of Dr. Amos), EX 17 at 12 (Ms. Cohen's testimony). Moreover, Dr. Amos has more recently opined that the claimant is not at this time able to obtain and maintain any type of reasonably continuous employment. CX 17 at 18.

Third, although the medical records show that the claimant regularly uses narcotic pain medication (Percocet), Ms. Cohen's vocational analysis fails to indicate what impact this prescription drug use would have on the claimant's ability to perform a job or on a potential employer's willingness to hire him.

C. Entitlement to Permanent Partial Disability Benefits for Alleged Knee Impairments

Even when an injured worker has suffered an injury to more than one part of his or her body, the total weekly benefits awarded to the worker under the Longshore Act cannot exceed two-thirds of the worker's average weekly wage at the time of his or her injury. See Brady-Hamilton Stevedore Co. v. Director, OWCP, 58 F.3d 419 (9th Cir. 1995); ITO Corp. of Baltimore v. Green, 185 F.3d 239 (4th Cir. 1999). Hence, even if the claimant were entitled to a scheduled award for his left knee injury, no such benefits could be paid until it had been determined that his entitlement to total temporary or total permanent disability benefits had ended. However, I find that even at such time as the claimant's entitlement to total disability benefits might cease, he would still not be entitled to a scheduled award for his left knee injury. In this regard, I note that the knee injury has been found to have reached the point of maximum medical improvement and that the claimant has not met his burden of establishing that the injury has resulted in any sort of permanent impairment. Indeed, the report of Dr. McNamara affirmatively establishes that there is no permanent left knee impairment attributable to the claimant's work injury. Moreover, the reports of Dr. Hormel and Dr. McCollom

convincingly show that any knee impairment the claimant may have subsequently developed is entirely attributable to causes other than his work injury.

4. Average Weekly Wage

A claimant's average weekly wage must be determined under one of three alternative standards set forth in subsections 10(a), 10(b), and 10(c) of the Longshore Act. Subsection 10(a) applies when a claimant worked in the same employment for “substantially the whole of the year” immediately preceding the injury. When this criterion is satisfied, the average weekly wage for a “five-day worker” is determined by multiplying his or her average daily wage during the one year period prior to the injury times 260 and then dividing by 52. Similarly, the average weekly wage for a “six day worker” is calculated by multiplying the worker’s average daily wage by 300 and dividing by 52. Subsection 10(b) applies when the claimant was not employed substantially the whole year preceding the injury, but there is evidence in the record of wages of a similarly situated employee who did work substantially the whole year. When subsection 10(b) applies, the similarly situated employee’s average daily wage is used to calculate an average weekly wage in the same manner set forth in subsection 10(a). When neither subsection 10(a) nor 10(b) can reasonably be applied, subsection 10(c) provides the general method for determining the appropriate average weekly wage. Under the express language of subsection 10(c), at least three factors must be given consideration: (1) the previous earnings of the claimant in the job in which he or she was working at the time of the injury, (2) the previous earnings of others engaged in similar employment, and (3) other employment of the injured employee, including self employment. In addition, the courts have held that since the underlying purpose of subsection 10(c) is to arrive at an accurate assessment of a claimant's actual earning capacity, it is also appropriate to consider other factors, such as an employee's "ability, willingness and opportunity to work." Tri-State Terminals, Inc. v. Jesse, 596 F.2d 752, 757 (7th Cir. 1979); Palacios v. Campbell Industries, 633 F.2d 840, 843 (9th Cir. 1980).

As a general rule, workers with permanent and continuous jobs fall under subsections 10(a) 10(b), while workers employed in seasonal and intermittent jobs fall under subsection 10(c). See Duncanson-Harrelson Company v. Director, Office of Workers' Compensation Programs, 686 F.2d 1336, 1341 (9th Cir. 1982), vacated in part on other grounds 462 U.S. 1101 (1983). See also Palacios v. Campbell Industries, 633 F.2d 840, 841-42 (9th Cir. 1980); SGS Control Services v. Director, OWCP, 86 F.3d 438 (5th Cir. 1996); Empire United Stevedores v. Gatlin, 936 F.2d 819, 822 (5th Cir. 1991). However, in Matulic v. Director, OWCP, 154 F.3d 1052 (9th Cir. 1998), the Ninth Circuit held that, notwithstanding the Duncanson-Harrelson decision, there is a “presumption” that subsection 10(a) should be applied unless its application would be “unreasonable or unfair” and that when a claimant has worked “more than 75 percent of the work days in the measuring year the presumption ... is not rebutted.” 154 F.3d at 1057-58. In other words, it appears that the Ninth Circuit has concluded that even when an injured worker has been only intermittently or seasonally employed, there is nonetheless an irrebuttable presumption that subsection 10(a) must be applied if the worker has managed to find work on more than 75 percent of relevant number of work days (e.g., on more than 195 days in the case of a five-day worker and on more than 225 days in the case of a six-day worker).

In this case, the claimant contends that his average weekly wage is should be calculated pursuant to the provisions of subsection 10(a) and that under such a calculation his average weekly wage is \$1,126.22---the amount that results from dividing the claimant's earnings in the year prior to his injury (\$58,563.39) by 52. In contrast, the employer contends that the claimant's earnings in the year prior to his injury are not representative of his actual pre-injury earning capacity and therefore his average weekly wage should be determined under the provisions of subsection 10(c) and based on his average annual earnings during the seven years prior to his injury. Such a calculation, the employer asserts, results in an average weekly wage of \$703.35.

Review of the evidence in the record indicates that the claimant was in fact employed on at least 75 percent of the work days in the year prior to his injury. See Tr. at 49-52 (claimant's testimony estimating that he worked at least 1800 actual hours in the 52 weeks preceding his injury). Hence, it would appear that he is eligible to have his average weekly wage calculated under the provisions of subsection 10(a). Unfortunately, however, neither party has offered the kind of payroll records that are needed in order to calculate the claimant's average daily wage. Accordingly, it is not possible to calculate the claimant's average weekly wage under the provisions of subsection 10(a). See Duhagon v. Metropolitan Stevedore Company, 169 F.3d 615, 618 (9th Cir. 1999); Lobus v. ITO Corp. of Baltimore, Inc., 24 BRBS 137, 140 (1990). Nor is there sufficient evidence for the calculation of an average weekly wage under the provision of subsection 10(b). As a result, the average weekly wage calculation must be made under the provisions of subsection 10(c).

I find that when the provisions of subsection 10(c) are applied to the facts of this case, the appropriate average weekly wage is the full amount sought by the claimant: \$1,126.22. There are several reasons for this conclusion. First, an average weekly wage of \$1,126.22 represents the claimant's actual average weekly earnings in the 52 weeks prior to his injury and is therefore the alternative that is most consistent with the Act's preference for basing an injured worker's benefits on his or her actual earnings in the year preceding an injury. Second, the employer's suggestion that the claimant's average weekly wage should not fully reflect the amounts that he earned in Alaska during July, August and September of 1996 is not legally justified. Although the claimant's weekly earnings during this period (\$2,000 to \$2500 per week) were substantially higher than his average weekly earnings while working during the rest of the year in the Seattle area, such variations hardly mean the wages were unrepresentative of the claimant's long-term earning capacity. In fact, it is hardly uncommon for the weekly wages of workers to vary dramatically from season to season or from place to place. It is undoubtedly for this reason that the Act ordinarily requires benefits to be based on an average of a claimant's weekly earnings over an entire year rather than some shorter period. Third, although the claimant's earnings in the year immediately prior to his injury were greater than his average earnings over the preceding seven years, basing the claimant's average weekly wage on his average earnings over seven years would improperly ignore the effects of inflation and any wage increases attributable to increased work experience. Moreover, Social Security wage records submitted by the claimant indicate that the claimant's earnings in the year prior to his injury were not a fluke but were, in fact, comparable to the amounts he earned during calendar year 1995. CX 13 at 150.

5. Medical Care

Under section 7 of the Act an employer is required to furnish an injured employee such medical treatment as is reasonable and necessary. A claimant establishes a prima facie case that his medical care is compensable if the evidence shows that a licensed physician has indicated that the treatment is necessary for a work-related condition. Turner v. Chesapeake & Potomac Telephone Company, 16 BRBS 255 (1984). If an employee's request for necessary treatment is denied or neglected by the employer, the employee is entitled to procure the treatment at the employer's expense. Atlantic & Gulf Stevedores, Inc. v. Neuman, 440 F.2d 908 (5th Cir. 1971); Roger's Terminal and Shipping Corp. v. Director, OWCP, 784 F.2d 687 (5th Cir. 1986); Hite v. Dresser Guiberson Pumping, 22 BRBS 87 (1989). In addition, the Court of Appeals for the Ninth Circuit has recently held that "when an injured employee is faced with competing medical opinions about the best way to treat his work-related injury, each of them medically reasonable, it is for the patient, not the employer or the [administrative law judge] to decide what is best for him." Amos v. Director, OWCP, 153 F.3d 1051 (9th Cir. 1998).

In this case, there is a dispute between the parties concerning the employer's responsibility to pay for medical examinations and treatment recommended by Dr. Amos. Although the record does not contain a complete list of all the examinations and treatments that Foss has refused to authorize, it is apparent that Foss has refused to pay for an MRI of the claimant's left shoulder, for additional physical therapy, and for psychotherapy with Dr. Knowles. It is also apparent that Foss has failed to submit any medical evidence that would satisfy its burden under the Amos decision of showing that the examinations and treatments recommended by Dr. Amos are, in fact, medically unreasonable. Accordingly, I find that the employer is obligated to pay for all examinations and treatment which have so far been recommended by Dr. Amos.

ORDER

1. Beginning on June 20, 1997 and until ordered otherwise, Foss Maritime shall pay the claimant compensation for temporary total disability due to the injuries to his left shoulder and elbow at a compensation rate of \$750.81 per week.

2. Foss Maritime shall pay interest on each unpaid installment of compensation from the date the compensation became due until the date of actual payment at the rates prescribed under the provisions of 28 U.S.C. §1961.

3. Foss Maritime shall receive credit for all compensation paid to the claimant since June 20, 1997.

4. The District Director shall make all calculations necessary to carry out this order.

5. Foss Maritime shall provide the claimant all reasonable and necessary medical care for the treatment of the June 19, 1997 injury to his left shoulder and elbow, including all medical treatment recommended so far by Dr. Amos.

6. Benefits for any permanent partial disability allegedly attributable to the injury to the claimant's left knee are hereby denied.

7. Counsel for the claimant shall within 20 days after service of this order submit a fully supported application for costs and fees to counsel for Foss Maritime and to the undersigned Administrative Law Judge. Within 20 days thereafter, counsel for Foss Maritime shall provide the claimant's counsel and the undersigned Administrative Law Judge with a written list specifically describing each and every objection to the proposed fees and costs. Within 20 days after receipt of such objections, the claimant's counsel shall verbally discuss each of the objections with counsel for Foss Maritime. If the two counsel thereupon agree on an appropriate award of fees and costs they shall file written notification within ten days and shall also provide a statement of the agreed-upon fees and costs. Alternatively, if the counsel disagree on any of the proposed fees and costs, the claimant's counsel shall within 15 days file a fully documented petition listing those fees and costs which are still in dispute and set forth a statement of the claimant's position regarding such fees and costs. Such petition shall also specifically identify those fees and costs which have not been disputed by counsel for Foss Maritime. Counsel for Foss Maritime shall have 15 days from the date of service of such application in which to respond. No reply to that reply will be permitted unless specifically authorized in advance.

Paul A. Mapes
Administrative Law Judge

Date_____

U.S. Department of Labor

Telephone (415) 744-6577
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Office of Administrative Law Judges
50 Fremont Street
Suite 2100
San Francisco, CA 94105

January 14, 2000

Russell Metz, Esquire
Metz & Associates
One Union Square, Suite 3002
600 University Street
Seattle, Washington 98101

Re: LaFontaine v. Foss Maritime
Case No. 1999-LHC-2129

Dear Mr. Metz:

In reviewing the post-trial briefs in the above-captioned matter, I noticed that both parties referred to testimony by Merrill Cohen. However, none of my files for this case includes a transcript of Ms. Cohen's testimony. Could you please let me know if any such testimony was ever taken and, if so, provide a copy for the record.

Sincerely yours,

Paul A. Mapes
Administrative Law Judge

cc: Terri L. Herring-Puz